Connecticut State Medical Society
Connecticut Society of Eye Physicians

Before the Insurance and Real Estate Committee
On March 6, 2014

House Bill No 5250 AN ACT CONCERNING CONTRACTS BETWEEN OPTOMETRISTS AND HEALTH INSURERS

Good Morning Senator Crisco, Representative Megna and distinguished members of the Insurance and Real Estate Committee, my name is David Emmel, M.D. and I am a board certified ophthalmologist and past president of the Connecticut Society of Eye Physicians. I am offering you testimony strongly opposing House Bill 5250; An Act Concerning Contracts between Optometrists and Health Insurers, and offering alternative language that we would be glad to support. I am here today to speak on behalf of The Connecticut State Medical Society and the Connecticut Society of Eye Physicians, an organization representing over 90% of the ophthalmologists in CT

First, I wish to thank the committee for bringing to light the practice of some health insurance plans who seek to dictate to health care providers the fees that they may charge patients for non-covered services. We agree that, if an insurer refuses to cover a service or product, they have relinquished control of, or any input into, the provision of that service or product, including the cost of that service. The choice of whether a non-covered service is desired is up to the patient. The insurer has, by its own admission, no interest in that service or product. Providing that service then becomes an agreement between the patient and the provider, assuming the costs, risks, and benefits have been fully disclosed. This is only fair.

We were surprised, however, that the language of the proposed bill was restricted only to optometry. Ophthalmologists participate equally in these plans. It seems discriminatory to request that only optometry be protected from this unfair practice. We would ask that ophthalmology also be included in this exemption.

For that matter, since this issue affects a much broader swath of health care,

we believe all health care providers should be included within the language of this bill. We have submitted the attached changes to this bill (see appendix).

Appendix to CSEP Testimony:

AN ACT CONCERNING CONTRACTS BETWEEN HEALTH SERVICES PROVIDERS AND HEALTH INSURERS

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-472h of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2015*):

(a) No insurer, health care center, fraternal benefit society, hospital service corporation, medical service corporation or other entity delivering, issuing for delivery, renewing, amending or continuing: [an]

(1) An individual or a group health services plan in this state shall include in any contract with a licensed provider pursuant to chapters 379, 380, 381,etc., that is entered into, renewed or amended on or after January 1, 2012, any provision that requires such provider to accept as payment an amount set by such insurer, center, society, corporation or entity for services or procedures provided to an insured or enrollee that are not covered benefits under such insured's or enrollee's plan.

(b) No health care provider shall charge more for services or procedures that are not covered benefits than such provider's usual and customary rate for such services, goods or procedures.

(c) (1) Each evidence of coverage for an individual or a group insurance plan shall include the following statement:

"IMPORTANT: If you opt to receive health services or procedures that are not covered benefits under this plan, a participating provider may charge you his or her usual and customary rate for such services or procedures. Prior to providing you with health services or procedures that are not covered benefits, the provider must provide you with an itemized treatment plan that includes each anticipated service, medical equipment and supplies, or procedure to be provided and the estimated cost of each such service, medical supply or procedure. To fully

understand your coverage, you may wish to review your evidence of coverage document."

(c)(2) The itemized list of services, medical supplies, and procedures shall disclose the credentials of the health care professional who will provide them.

(d) Each provider shall post, in a conspicuous place, a notice stating that services or procedures that are not covered benefits under an insurance policy or plan might not be offered at a discounted rate.

(e) The provisions of this section shall not apply to (1) a self-insured plan that covers specific health services, or (2) a contract that is incorporated in or derived from a collective bargaining agreement or in which some or all of the material terms are subject to a collective bargaining process.

We strongly believe that the interests of transparency, public safety, and consumer protection, will be served by this disclosure and it will allow the patient to compare the proposed services with those from other providers.

In closing, I strongly urge this committee to reject HB 5250 as written and consider broadening the scope of this bill to include all health providers, and give the people of Connecticut additional choice and transparency when seeking non-covered health services.

Thank you for your time and attention.